Advisory Panel on APCs
Day One
January 21, 2003

Registration for members	7:45-8:30 AM
Welcome Tom Grissom, Director Center for Medicare Management,CMS Paul Rudolf, M.D., J.D. Chair, Advisory Panel on APCs	8:30-8:45 AM
Introduction Chair and Members of Panel Members	8:45-9:00 AM

[The agenda items will be discussed by Ken Simon, M.D., Paul Rudolf, M.D., J.D., and Laurie Feinberg, M.D.]

A. Debridement and Destruction (APCs 0012-0013)	9:00-9:15 AM
B. Excision/Biopsy (APCs 0019, 0020, 0021)	9:15-9:30 AM
C. Thoracentesis/Lavage Procedures and Endoscopy (APCs 0071, 0072, 0073)	9:30-9:45 AM
D. Cardiac and Ambulatory Blood Pressure Monitoring (APC 0097)	9:45-10:00 AM
E. Electrocardiograms (APCs 0099 and 340)	10:00-10:15 AM
F. Cardiac Stress Tests (APC 0100)	10:15-10:30 AM
G. Revision/Removal of Pacemakers of AICD, or Vascular (APC 0105)	10:30-10:45 AM
H. Sigmoidoscopy (APCs 0146-0147)	10:45-11:15 PM
I. Anal/Rectal Procedures (APCs 0148, 0149, 0155)	11:15-11:30
J. Insertion of Penile Prosthesis (APC 0182)	11:30-12:00 Noon
LUNCH	12:00-1:00 PM

K. Female Reproductive Procedures (APCs 0195, 0202)	1:00-1:30 PM
L. Surgical Hysteroscopy (APC 0190)	1:30-1:45 PM
M. Nerve Injections (APCs 0203, 0204, 0206, 0207)	1:45-2:00 PM
N. Laminotomies and Laminectomies; Implantation of Pain Management Device (APCs 0208, 0223)	2:00-2:30 PM
O. Extended EEG Studies and Sleep Studies; Electroencephalogram (APCs 0209, 0213, and 0214)	2:30-2:45 PM
P. Nerve and Muscle Tests (APCs 0215, 0216, and 0218)	2:45-3:15 PM
Q. Implantation of Drug Infusion Device (APC 0227)	3:15-3:45 PM
R. Opthamologic APCs (APCs 0230, 0235, 0236, and 698)	3:45-4:00 PM
S. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures (APCs 0341-0345)	4:00-4:15 PM
T. Otorhinolaryngologic Function Tests (APCs 0363, 0660)	4:15-4:30 PM
U. Tube changes and repositioning (APCs 0121-0122)	4:30-4:45 PM
V. Myelography (APC 0274)	4:45-5:00 PM

Advisory Panel on APCs
Day Two
January 22, 2003

W. Therapeutic Radiologic Procedures (APCs 0296-0297)	8:30-8:45 AM
X. Vascular Procedures; Cannula/Access Device Procedures (APCs 0103, 0115)	8:45-9:00 AM
Y. Angiography and Venography except Extremity (APCs 0279, 0280 and 0668)	9:00-9:15 AM
Z. CT, MR, and U/S Guidance procedure currently packaged	9:15-9:45 AM
AA Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast (APC 0336)	
BB. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement (APCs 0260 an 0261)	9:45-10:00 AM
CC. Chemotherapy Administration by Other Technique Except Infusion (APC 0116)	10:15-10:30 AM
DD. Diagnostic Nuclear Medicine Excluding Myocardial Scans (APCs 0290, 0291, 0292, 0294, and 666)	10:30-11:30 AM
EE. Capturing the Costs of Drugs and Biologicals packaged into APCs	11:30-12:30 PM
LUNCH	12:30-1:30 PM
FF. Endoscopy Lower Airway (APC 0076)	1:30-1:45 PM
GG. Gastrointestinal Endoscopic Stenting Procedures (APCs 0141, 0142, 0143, and 0147)	1:45-2:00 PM
HH. Device-related Procedures (APCs 0081, 0083, 0104, 0222, 0223, 0227, 0229 and others)	2:00-3:00 PM
II. Capturing the Costs of Devices that are packaged into APCs	3:00-4:00 PM
JJ. Discussion of Ways to Increase the Use of Multiple Claims to Set APC Payment Rates	4:00 – 5:00 PM

A. Debridement and Destruction (APCs 0012 and 0013)

Issue: APCs 0012 & 0013 appear to violate the 2 times rule. CMS is proposing the following changes to resolve the violations.

CMS's Proposal:
1) Move the following codes: 15793, 15786, 11001, 16025, 16000, 15851, and 11302 from APC 0013 to APC 0012; and
2) Move code 11057 from APC 0012 to APC 0013.

Request: CMS requests the Panel's input as to whether these or other changes should be made.

B. Excision/Biopsy (APCs 0019, 0020 and 0021)

Issue: APCs 0019 and 0020 appear to violate the 2 times rule. CMS is proposing the following changes to resolve the violations.

CMS's Proposal:
1) Move the following codes: 56606, 69100, 56605, 28190, 11976, 24200, and 11755 from APC 0019 to APC 0019A; and
2) Move codes 11604, 11423, 11404, and 11623 from APC 0020 to APC 0021.

Request: CMS requests the Panel's input as to whether these or other changes should be made.

C. Thoracentesis/Lavage Procedures and Endoscopy (APCs 0071, 0072, and 0073)

Issue: APCs 0071 and 0072 appear to violate the 2 times rule. CMS is proposing the following changes to resolve the violations.

CMS's Proposal:
1) Move code 31505 from APC 0072 to APC 0071;
2) Move code 31575 from APC 0071 to APC 0072; and
3) Move code 31720 from APC 0072 to APC 0073.

Request: CMS requests the Panel's input as to whether these or other changes should be made.

D. Cardiac and Ambulatory Blood Pressure Monitoring (APC 0097)

Issue: APC 0097 appears to violate the 2 times rule.

Request: CMS requests that the Panel recommend options for resolving the current 2 times violation, one of which could involve splitting APC 0097 into two APCs.

E. Electrocardiograms (APC 0099)

Issue: APC 0099 appears to minimally violate the 2 times rule.

CMS is proposing one of the following options:
1) Keep the current APC configuration; or
2) Move code 93701 to APC 0340.

Request: CMS requests the Panel to consider more clinically homogenous groupings that would also resolve the current 2 times violations.

F. Cardiac Stress Tests (APC 0100)

Issue: A commenter requested that code 93025 be moved out of APC 0100.

Request: CMS requests the Panel's input as to whether this change should be made.

G. Revision/Removal of Pacemakers of AICD, or Vascular (APC 0105)

Issue: APC 0105 appears to violate the 2 times rule. CMS believes that C-codes were incorrectly billed with these procedures, inappropriately increasing the apparent cost of some procedures and causing the 2 times violation.

CMS's Proposal:
Keep the current APC configuration since it is clinically homogenous, and the 2 times violation appears to be a result of poor coding.

Request: CMS requests that the Panel consider options for restructuring this APC.

H. Sigmoidoscopy (APCs 0146 and 0147)

Issue: Anoscopies and rigid sigmoidoscopies (simpler procedures) have higher median costs than comparable flexible sigmoidoscopies (more complex procedures). It is unclear why this

should be the case. Currently, certain anoscopies, rigid sigmoidoscopies, and flexible sigmoidoscopies are placed together in APCs 0146 and 0147.

Request: CMS requests the Panel's input as to why anoscopies and rigid sigmoidoscopies appear to have higher median costs than comparable flexible sigmoidoscopies. CMS also requests the Panel to consider options for restructuring these APCs.

I. Anal/Rectal Procedures (APCs 0148, 0149, and 0155)

APC 0148

Issue: APC 0148 appears to violate the 2 times rule.

CMS's Position: Code 46320 appears to have an inordinately high median cost.

Request: CMS requests the Panel's input as to why code 46320 seems to have an inordinately high median cost. CMS requests that the Panel consider options for resolving the current 2 times violation for APC 0148.

APCs 0149 and 0155

Issue: APC 0149 appears to violate the 2 times rule.

CMS's Proposal: Move code 46040 from APC 0155 to APC 0149.

Request: CMS requests the Panel's input as to whether this or other changes should be made.

J. Insertion of Penile Prosthesis (APC 0182)

Issue: A commenter recommended that APC 0182 be split into two separate APCs: (1) procedures using non-inflatable penile prosthesis; and (2) procedures using inflatable penile prosthesis.

Request: CMS requests that the Panel consider whether APC 0182 should be split into two separate APCs.

K. Female Reproductive Procedures (APCs 0195 and 0202)

Issue: A commenter suggested that code 57288 be placed in its own APC because it requires the use of a device.

CMS's Proposal:

1) Move codes 57109, 58920, and 58925 from APC 0202 to APC 0195; and
2) Keep codes 57287 & 57288 in APC 0202 since they both require the use of a device.

Request: CMS requests the Panel's input as to whether these or other changes should be made.

L. Surgical Hysteroscopy (APC 0190)

Issue: A commenter requested that code 58563 be moved out of APC 0190 and placed into its own APC.

Request: CMS requests the Panel's input as to whether this change should be made.

M. Nerve Injections (APCs 0203, 0204, 0206, and 0207)

Issue: Several commenters suggested changes in the configuration of these APCs because of concerns that the current classifications result in payment rates that are too low relative to the resource costs associated with certain procedures in these APCs. Several of these APCs include procedures associated with drugs or with device categories for which pass-through payments are scheduled to expire in 2003.

CMS's Position: CMS is not proposing any changes to these APCs because the current configuration of these APCs reflects previous Panel recommendations, and because CMS believes more data should be collected prior to making any changes.

Request: CMS requests that the Panel discuss the configuration of these APCs.

N. Laminotomies and Laminectomies; Implantation of Pain Management Device (APCs 0208 and 0223)

Issue: A commenter expressed concern over code 62351 (implantation of catheter with a laminectomy) being assigned to APC 0208 (laminotomies and laminectomies), while code 62350 (implantation of catheter without a laminectomy) is assigned to the higher paying APC 0223 (implantation of pain management device). The commenter urged that code 62351 be assigned to the higher paying APC 0223.

Request: CMS requests the Panel's input as to whether this change should be made.

O. Extended EEG Studies and Sleep Studies; Electroencephalogram (APCs 0209, 0213, and 0214)

Issue: APC 0213 appears to minimally violate the 2 times rule. One commenter requested that code 95955 be moved from APC 0214 to APC 0213.

Request: CMS requests the Panel's input as to whether any codes should be moved among APCs 0209, 0213, and 0214 to resolve the minimal violation of the 2 times rule for APC 0213.

P. Nerve and Muscle Tests (APCs 0215, 0216, and 0218)

Issue: APC 0218 appears to violate the 2 times rule.

Proposals:
1) From CMS--move codes 95858, 95922, 95870, 95900, and 95903 from APC 0218 to APC 0215;
2) From commenters--move codes 95921 & 95922 from APC 0218 to APC 0216; and
3) From commenters--move code 95904 from APC 0215 to APC 0218.

Request: CMS requests that the Panel discuss these proposals.

Q. Implantation of Drug Infusion Device (APC 0227)

Issue: There are two CPT codes in APC 0227, one for insertion of programmable infusion pumps (code 62361) and one for insertion of non-programmable infusion pumps (62362). A commenter requested that we split this APC to recognize the cost differences related to these infusion pumps. CMS cost data does not show a significant difference in cost between these procedures.

Request: Although APC 0227 does not violate the 2 times rule, CMS requests the Panel's input as to whether APC 0227 should be split to recognize cost differences between these pumps.

R. Opthamologic APCs (APCs 0230, 0235, and 0236)

Issue: APCs 0230 & 0235 appear to violate the 2 times rule; however, last year most of the opthamologic APCs violated the 2 times rule. The current configuration of APC 0230 reflects last year's Panel recommendation.

CMS's Proposal:
Move code 67820 from APC 0230 to 0698; and move code 67110 from APC 0235 to 0236.

Request: CMS requests the Panel's input as to whether these or other changes should be made.

S. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures (APCs 0341 and 0345)

Issue: APCs 0341 & 0345 appear to minimally violate the 2 times rule. A commenter expressed concern over the combination of skin tests and miscellaneous red blood cell tests in APC 0341, asserting that services within this group cannot be considered comparable with respect to resource usage.

CMS's Proposal:
Move codes 86880, 86885, 86886, and 86900 (all from APC 0341) & 86901 (from APC 0345) to their own APC.

Request: CMS requests the Panel's input for any changes to the configuration of these APCs.

T. Otorhinolaryngologic Function Tests (APCs 0363 and 0660)

Issue: APC 0660 appears to violate the 2 times rule.

CMS's Proposal: Move codes 92543 & 92588 from APC 0660 to APC 0363.

Request: CMS requests the Panel's input as to whether these changes should be made.

U. Tube changes and repositioning (APCs 0121 and 0122)

Issue: APC 0121 appears to violate the 2 times rule.

CMS's Proposal: Move codes 43760, 47530, 51710, 50688, and 62225 from APC 0121 to APC 0122.

Request: CMS requests the Panel's input as to whether these or other changes should be made.

V. Myelography (APC 0274)

Issue: APC 0274 appears to violate the 2 times rule.

CMS's Proposal: Move codes 72285 & 72295 from APC 0274 to APC 0274A. These changes would make the APCs more homogenous.

Request: CMS requests the Panel's input as to whether these or other changes should be made.

W. Therapeutic Radiologic Procedures (APCs 0296 and 0297)

Issue: APCs 0296 & 0297 appear to minimally violate the 2 times rule. The current configuration of these APCs is based on last year's Panel recommendation.

CMS's Position: CMS proposes no additional changes since the 2 times violation is minimal.

Request: CMS requests the Panel's input for any further changes to the configuration of these APCs.

X. Vascular Procedures; Cannula/Access Device Procedures (APCs 0103 and 0115)

Issue: A commenter expressed concern over placement of code 36830 in APC 0103 and requested to have code 36860 returned to APC 0115.

Request: CMS requests the Panel's input as to whether these changes should be made.

Y. Angiography and Venography except Extremity (APCs 0279, 0280 and 0668)

Issue: A commenter requested that code 75978 be returned to APC 0280 (from APC 0668); and code 75774 be returned to APC 0279 (from APC 0668).

Request: CMS requests the Panel's input as to whether these changes should be made.

Z. CT, MR, and U/S Guidance procedures that are currently packaged

Issue: A commenter requested that the status indicator for codes 76362, 76394, and 76490 be changed from "N" to "S" and that these codes be placed in an appropriate clinical or new technology APC.

Request: CMS requests the Panel's input as to whether these changes should be made.

AA. Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast (APC 0336)

Issue: A commenter requested that the status indicator for code 76393 be changed from "N" to "S" and that this code be placed in APC 0336.

Request: CMS requests the Panel's input as to whether this change should be made.

BB. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement (APCs 0260 an 0261)

Issue: A commenter requested that codes 76120 and 76125 be moved from APC 0260 to APC 0261.

Request: CMS requests the Panel's input as to whether these changes should be made.

CC. Chemotherapy Administration by Other Technique Except Infusion (APC 0116)

Issue: A commenter requested that APC 0116 be split into three APCs to describe the different types of non-infusional chemotherapy (e.g., subq- and CNS administration)

Request: CMS requests the Panel's input as to whether this change should be made.

DD. Diagnostic Nuclear Medicine Excluding Myocardial Scans (APCs 0290, 0291, 0292, 0294 and 0666)

Issue: APCs 0290 & 0291 appear to violate the 2 times rule. However, the current configuration is based on recommendations of the Nuclear Medicine APC Task Force. Furthermore, CMS has now packaged radiopharmaceuticals whose costs are less than $150, which may make these APCs less homogeneous in terms of resource use.

Request: CMS requests the Panel's input regarding changes to the configuration of these APCs.

EE. Capturing the Costs of Drugs and Biologicals that are packaged into APCs

Issue: CMS seeks to assure that the costs of drugs and biologicals packaged into APCs are appropriately captured in the payment amount for that APC.

Request: CMS asks the panel to recommend ways for CMS to achieve this objective.

Attached are three spreadsheets that show the hospital reported costs for drugs and biologicals that were separately payable during the time period April 1, 2002 through September 30, 2002.

CMS will discuss this data.

Definition of Column Headings on Spreadsheets

SI = Payment status indicator for OPPS

G = Pass-through drug or biological
K = Non pass-through drug or biological

Freq = Total number of line items billed

Units = Total number of units billed on all line items

Total Cost = Sum of costs from all line items

MeanCost per Unit = Mean cost per unit

MedCost per Unit = Median cost per unit

MedCost per Line = Median cost per line

FF. Endoscopy Lower Airway (APC 0076)

Issue: A commenter requested that code 31631 be moved out of APC 0076 and placed into a different APC.

Request: CMS requests the Panel's input as to whether this change should be made.

GG. Gastrointestinal Endoscopic Stenting Procedures (APCs 0141, 0142, 0143, and 0147)

Issue: A commenter requested that codes 43219 and 43256 (both in APC 0141), 44370 (in APC 0142), 44379 (in APC 0142), 44383 (in APC 0142), 44397 (in APC 0143), 45387 (in APC 0143), 45327 (in APC 0147), and 45345 (in APC 0147) be moved into a single, newly created APC.

Request: CMS requests the Panel's input as to whether these changes should be made.

HH. Device-related Procedures (APCs 0081, 0083, 0104, 0222, 0223, 0227, 0229, et al)

Issue: Commenters urged that the status indicators for these APCs be changed from "T" to "S" so that the multiple procedure discounting rule would not be applied to these APCs. The reason for this recommendation is that these APCs include procedures using high cost devices. CMS's long established payment policy (for both the physician and outpatient hospital fee schedule) for situations where more than one surgical procedure is performed on a patient, is to pay 100% of the most expensive surgical procedure and 50% for each additional surgical procedure.

Request: CMS requests the Panel's input as to whether there are any circumstances where CMS should not apply its multiple procedure discounting policy to these and other APCs. CMS also requests data showing which procedures from these and other APCs are performed together and the frequency with which they are performed together.

Please see the attached spreadsheet for claims data for these APCs from April 1, 2001-March 31, 2002.

Definition of Column Headings on Spreadsheet

APC 1 = 1st APC of interest

APC 2 = 2nd APC of interest

HCPCS2 = is a code in APC2 billed on same claim as APC 1

Comb Freq = # of times HCPCS2 was billed with APC1

Single Freq = # of single procedure claims billed with HCPCS2

Total Freq = total # of claims where HCPCS2 appeared

II. Capturing the Cost of Devices that are packaged into APCs

Issue: CMS seeks to ensure that the cost of devices, formerly reported by use of C-codes, are appropriately captured in the APC payment under which payment for the devices will be made (e.g., the cost of a defibrillator is accurately reflected in the cost of the code for inserting the defibrillator).

Request: CMS requests the Panel's input on ways to ensure that these costs are properly reflected. We specifically request input as to how CMS can work with hospitals and other entities to ensure that claims for these procedures reflect charges for the devices and how CMS can better utilize its claims data for these procedures.

JJ. Discussion of Ways to Increase the Use of Multiple Claims to Set APC Payment Rates

Request: CMS requests that the Panel discuss ways to increase the number of claims used to set APC payment rates.

Attached is a spreadsheet that includes only APCs where less than 50% of total claims were used to set payment rates. Also shown are separately payable HCPCS codes or code combinations (from other APCs) that appeared on claims for those APCs, so long as the

separately payable code(s) appeared on 1% or more of the claims for the APC of interest. CMS will present this spreadsheet in more detail at the panel meeting and discuss ways of using this information. Please note that CMS already ignores HCPCS codes for chest x-rays and EKGs when they make a claim from another APC into a multiple claim.

Definition of Column Headings on Spreadsheet

APC = APC of interest

COMB = the code or codes that were billed with the APC

AFREQ = the total # of claims for the APC

CFREQ = frequency of combined occurrence of base APC with the separately payable codes

CPCTG = CFREQ divided by AFREQ (as a percent of total claims for the APC of interest).